



425 I Street, NW • Suite 701  
Washington, DC 20001  
202-220-3700 • Fax: 202-220-3759  
www.medpac.gov

Michael E. Chernew, Ph.D., Chairman  
Paul B. Ginsburg, Ph.D., Vice Chairman  
James E. Mathews, Ph.D., Executive Director

August 21, 2020

Seema Verma, MPH  
Administrator  
Centers for Medicare & Medicaid Services  
Department of Health and Human Services  
200 Independence Avenue, SW  
Washington, DC 20201

**RE: CMS-1730-P**

Dear Ms. Verma:

The Medicare Payment Advisory Commission (MedPAC) appreciates the opportunity to submit comments on the Centers for Medicare & Medicaid Services' (CMS's) proposed rule entitled "Medicare and Medicaid programs; Calendar year 2021 home health prospective payment system rate update; home health quality reporting requirements; and home infusion therapy services requirements," *Federal Register*, vol. 85, no. 126, p. 39408 (June 30, 2020). We appreciate your staff's efforts to administer and improve the Medicare program for beneficiaries and providers, particularly given the considerable demands on the agency.

Our comments address proposals in the rule related to Medicare payment policies for home health agencies (HHAs), including:

- Calendar year (CY) 2021 national standardized 30-day episode payment rates,
- Use of technology under the Medicare home health benefit, and
- Adopting the Office of Management and Budget's changes to geographic area delineations to establish hospital wage indexes for the home health prospective payment system (PPS).

**Proposed CY 2021 national standardized 30-day episode payment rate**

The proposed rule would implement a 2.7 percent update to the base payment rate for home health agency (HHA) services. This increase reflects payment adjustments mandated by statute: a 3.1 percent home health market basket update for 2021 reduced by the multifactor productivity adjustment of 0.4 percent.

*Comment*

The Commission recognizes that CMS must provide the statutorily mandated payment update, but we note that this increase is not warranted based on our analysis of payment adequacy. In our March 2020 report to the Congress, the Commission found positive access, quality, and financial indicators for the sector, with margins of 15.3 percent for freestanding HHAs in 2018.<sup>1</sup> A payment update of 2.7 percent likely will raise agency margins even higher, widening the gap between Medicare's payments for home health care and the actual costs of care. Payments substantially in excess of costs diminish the value of home health services as a substitute for more costly services. Such payments may also encourage fraud, waste, and abuse in the Medicare home health benefit. To begin to address the magnitude of overpayments, the Commission recommended that, for the 2021 payment year, the Congress should reduce the calendar year 2020 Medicare base payment rate for home health agencies by 7 percent.

The Commission recognizes that the COVID-19 public health emergency (PHE) has had an effect on the home health benefit, and is monitoring its effects. The PHE has reportedly affected the costs incurred and payments received by HHAs in 2020. Agencies have indicated they are incurring higher costs for personal protective equipment, and some agencies initially reported declines in volume when hospitals and other facilities halted referrals to home health care, and beneficiaries declined to receive services.

However, HHAs have been able to mitigate the negative impacts of the PHE in several ways. Agencies have reported using furloughs and other measures to reduce staffing costs as the volume of patients declined. In addition, HHAs reportedly have received funds from the Paycheck Protection Program and the deferral of payroll tax payments by employers. Some HHAs have reported that volume has started to recover recently.

As the PHE is ongoing, the net effect—both short term and long term—on the home health industry is not yet clear. The short-term measures implemented to date have provided some immediate relief. We do not yet know whether the sector will experience longer-term structural changes that warrant adjustment through the annual payment update. The Commission will continue to review the impact of the PHE and account for it in future analytic work, and for now reiterates the recommendation from our March 2020 report to the Congress.

### **The use of technology under the Medicare home health benefit**

The Benefits Improvement and Protection Act of 2000 (BIPA)<sup>2</sup> establishes that HHAs are not prohibited by Medicare statute from providing "telecommunications services" (which the Act did not further define). The statute prohibits these services from serving as a substitute for in-person home visits and states that these telecommunication services are not considered covered visits for

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<sup>1</sup> Medicare Payment Advisory Commission. 2020. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

<sup>2</sup> Medicare, Medicaid, and SCHIP Benefits Improvement and Protection Act of 2000, Public Law 106-554.

purposes of eligibility or payment under Medicare. Since 2000, HHAs have implemented a broad range of telehealth services but, until recently, the cost of these services has not been recognized by Medicare.

In 2019, CMS modified its program regulations to permit HHAs to report the costs associated with remote patient monitoring. CMS defined remote patient monitoring as the digital storage and transmittal of physiological data by the patient to a home health agency. Agencies that used this modality for care planning were permitted to report it as a Medicare-allowable expense beginning in 2019. Only costs associated with the equipment and services related to remote patient monitoring could be reported. HHAs could continue to use other modalities of telehealth, as allowed by BIPA, but could not report costs associated with other modalities on the Medicare cost report.

On April 6, 2020, CMS published an interim final rule that, among other policies, permitted HHAs to report as a Medicare-allowable cost “other services furnished via telecommunications” during the PHE.<sup>3</sup> The “other services furnished via telecommunications” were not defined in the rule, but some examples were cited:

- The use of two-way video consults between nurses furnishing a home visit and a specialty clinician at the HHA.
- Specialized software that permits detailed assessment of the depth and surface area of surgical wounds and skin ulcers.
- An application that tracks appetite, mental health changes, biometrics, and other measures of patients at risk for sepsis through digital daily “check-ins.”

In effect, the interim final rule expanded the modalities of telehealth that could be reported as Medicare-allowable costs for the duration of the PHE. In this year’s proposed rule for the home health PPS, CMS noted that these technologies have application beyond the COVID-19 PHE. The rule thus proposes to make “other services furnished by telecommunications” an allowable cost under Medicare on a permanent basis.

#### *Comment*

We recognize the unique and difficult circumstances in which CMS currently operates under the PHE. However, we are concerned about the broader implications of recognizing all services furnished via telecommunications as allowable costs on a permanent basis. In our March 2018 report to the Congress, the Commission advised policymakers to adopt a measured approach to expanding the coverage of telehealth services in the Medicare program, basing such decisions on

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<sup>3</sup> Under the interim final rule, the remote patient monitoring or other telecommunication services cannot substitute for in-person visits ordered by the physician authorizing home health care. The plan of care must indicate how the use of such technology is related to the goals of the home health care episode. (Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2020. Medicare and Medicaid programs; Policy and regulatory revisions in response to the COVID-19 public health emergency. *Federal Register* 85, no. 66 (April 6): 19230–19292.)

evidence that these technologies have favorable impacts on cost, access, and quality of care.<sup>4</sup> In the absence of such evaluation, we do not support “other services provided via telecommunications” as an allowable cost under Medicare on a permanent basis at this time.

Medicare needs to consider how services provided via telecommunications will change the delivery of care before broader recognition as a Medicare-allowable cost is implemented. In-person assessment and clinical care in a patient’s residence has been a defining attribute of the Medicare home health care benefit, and the potential shift to more reliance on telehealth services raises policy issues that should be addressed before these services are recognized. Telehealth technologies have the potential to fundamentally change how care is delivered in the home. The evidence is still evolving about the capacity of these technologies to improve care for beneficiaries. A vaguely defined category such as “other services provided via telecommunications” has the potential to unintentionally promote inefficient or wasteful utilization that increases costs without yielding better outcomes or that reduces costs while yielding worse outcomes. While the rule would require that the services support goals included on the home health plan of care, this requirement may not be sufficient to ensure judicious use of these new services. The Commission acknowledges that existing statute already permits HHAs to provide these services, but recognizing them as a cost may accelerate adoption. Given the challenges of fraud, waste, and abuse in the home health benefit, creating a new category of vaguely defined services could increase the vulnerabilities to the Medicare program.

If this change is implemented, additional safeguards should be in place to ensure that beneficiaries and the Medicare program are protected. For example, Medicare will need safeguards to ensure that in-person care is provided at adequate levels under this broad definition of telehealth; however, the proposed rule includes no guidance to address this issue. As another example, if telehealth reduces the cost of home health care, it may create an incentive for patient selection, causing agencies to favor patients who benefit from these services and avoid those who do not benefit. The proposed rule does not provide any indication for how CMS intends to protect patient access to care or safeguard against stinting on in-person visits.

Further, such monitoring may prove challenging because the rule does not require HHAs to indicate on claims or patient assessments when an episode includes “other services provided via telecommunications.” The lack of reporting will make it difficult to identify how and when agencies are using these services, what services are being used, how their use affects the mix and frequency of in-person home health care visits, and whether aberrant patterns of utilization are suggestive of fraud, waste, or abuse. If CMS proceeds with this proposal, it should indicate how, in the absence of patient-level reporting, the agency plans to assess the impact of “other services provided via telecommunications” and ensure access to and quality of care while maintaining program integrity. In 2018, the Commission suggested that CMS require reporting when remote

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<sup>4</sup> Medicare Payment Advisory Commission. 2018. *Report to the Congress: Medicare payment policy*. Washington, DC: MedPAC.

patient monitoring was used in an episode, but CMS has not yet implemented reporting for this category of service.<sup>5</sup>

Adding a new category of broadly defined services could also reduce the accuracy of home health agency cost reports, as past experience suggests that HHAs struggle to accurately account for existing services under current guidance. For example, CMS audited a sample of HHA cost reports in 2011 and found that providers substantially overstated the costs of many services and included many non-allowable costs.<sup>6</sup> Including “other services provided via telecommunications” would create a new category of Medicare-allowable costs that, because it is not clearly defined, could potentially result in erroneous reporting, distorting the financial information that CMS uses to set payment weights and analyze payment rates and that the Commission uses in its payment adequacy analyses. In 2018, when Medicare proposed that HHAs report the costs associated with remote patient monitoring, CMS established a definition of these services that facilitated accurate reporting. A clear definition of “other” telehealth services will be required here as well.

### **Adopting the Office of Management and Budget’s changes to geographic area delineations to establish hospital wage indexes for the home health PPS**

The payment rates for home health care services are adjusted to reflect the relative differences in area wage levels using geographic areas (called core-based statistical areas, or CBSAs) delineated by the Office of Management and Budget (OMB).<sup>7</sup> Periodically, OMB revises the delineations and CMS adopts them in establishing the wage index values. In 2018, OMB published an updated set of delineations that included the creation of new CBSAs, the splitting of some existing CBSAs, and changes in the designation of some areas from rural to urban and from urban to rural.<sup>8</sup>

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<sup>5</sup> Medicare Payment Advisory Commission. 2018. Comment letter for “*Medicare and Medicaid programs; CY 2019 home health prospective payment system rate update and 2020 case-mix adjustment methodology refinements; home health value-based purchasing model; home health quality reporting requirements; home infusion therapy requirements; and training requirements for surveyors of national accrediting organizations,*” CMS-1689-P. August 30.

<sup>6</sup> According to CMS, the inappropriate costs reported by HHAs included “excess salary expense and/or excess owner’s compensation, private duty nursing costs, luxury auto expenses, non-allowable costs for marketing/advertising/public relations, federal tax preparation for an HHA owner, landscaping fees for an HHA owner’s home, and lobbying expenses.” (Centers for Medicare & Medicaid Services, Department of Health and Human Services. 2013. Medicare and Medicaid programs; home health prospective payment system rate update for CY 2014, home health quality reporting requirements, and cost allocation of home health survey expenses. Final rule. *Federal Register* no. 78 (December 2): 72556–72320.)

<sup>7</sup> The home health wage index is based on the pre-floor, pre-reclassified hospital inpatient prospective payment system wage index. Unlike most other Medicare payment systems, the local area adjustment for home health services is determined by the beneficiary’s county in which they received service rather than the provider’s location.

<sup>8</sup> On April 10, 2018, OMB issued OMB Bulletin No. 18-03, which superseded the August 15, 2017, OMB Bulletin No. 17-01. On September 14, 2018, OMB issued OMB Bulletin No. 18–04, which superseded the April 10, 2018, OMB Bulletin No. 18-03. CMS was unable to complete an exhaustive review of the changes in these 2018 OMB bulletins prior to the issuance of the FY 2019 IPPS/LTCH rule. OMB issued another interim bulletin on March 6, 2020, which CMS stated was not issued in time for inclusion in the development of the FY 2021 proposed rule.

For CY 2021, CMS proposes to adopt the 2018 OMB delineations of geographic areas. Consistent with the wage index transition policy implemented in other sectors, CMS proposes a 5 percent limit on wage index reductions, thus mitigating the impact on hospitals whose wage index values will decrease. The adoption of the new wage index values would be done in a budget-neutral manner.

*Comment*

The Commission supports the adoption of the new delineations of the geographic areas. Regarding the limit on decreases to the wage index values, the Commission supports eliminating wage index declines of more than 5 percent in one year. However, the Commission believes the limit should apply to both increases and decreases in the wage index, not just decreases. As a result, no provider would have its wage index value increase or decrease by more than 5 percent for 2021. Consistent with CMS's proposed approach and statute, the implementation of the revised relative wage index values (where changes are limited to plus or minus 5 percent) should be done in a budget-neutral manner.

The Commission also reiterates its June 2007 recommendations on wage index reform.<sup>9</sup> We recommended that the Congress repeal the existing hospital wage index and instead implement a market-level wage index for use across the inpatient prospective payment system and other prospective payment systems, including certain post-acute care providers. Specifically, our recommended wage index system would:

- use wage data from all employers and industry-specific occupational weights,
- adjust for geographic differences in the ratio of benefits to wages,
- adjust at the county level and smooth large differences between counties, and
- include a transition period to mitigate large changes in wage index values.

Compared with the current system, the wage index system we proposed would more fully reflect input prices, automatically adjust for occupational mix, reduce circularity, and reduce large differences between adjoining areas. Two significant research evaluations commissioned by the Secretary concluded that MedPAC's proposed wage index system would be an improvement over

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<sup>9</sup> Medicare Payment Advisory Commission. 2007. *Report to the Congress: Promoting greater efficiency in Medicare*. Washington, DC: MedPAC.

Medicare's current hospital wage index system.<sup>10,11</sup> We urge the agency to consider our recommendations and implement a revised home health wage index.

## Conclusion

The Commission appreciates the opportunity to comment on the important policy proposals crafted by the Secretary and CMS. We also value the ongoing cooperation and collaboration between CMS and MedPAC staff on technical policy issues. We look forward to continuing this productive relationship.

If you have any questions, or require clarification of our comments, please feel free to contact James E. Mathews, MedPAC's Executive Director, at (202) 220-3700.

Sincerely,

A handwritten signature in black ink, appearing to read "m. chernew", with a horizontal line extending to the right from the end of the signature.

Michael E. Chernew, Ph.D.  
Chairman

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<sup>10</sup> Institute of Medicine. 2011. *Geographic adjustment in Medicare payment, Phase I: Improving accuracy*. Second edition. Washington, DC: The National Academies Press.

<sup>11</sup> MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2009. Revision of Medicare Wage Index. Final Report, Part I. MaCurdy, T, T. DeLeire, K. Lopez de Nava. et al. 2010. Revision of Medicare Wage Index. Final Report, Part II. <https://www.cms.gov/Medicare/Medicare-Fee-for-Service-Payment/AcuteInpatientPPS/Wage-Index-Files-Items/CMS1237065.html>.